STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	08/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROWNPOINTE OF ANDERSON	2727 CROWNPOINTE CIRCLE ANDERSON, IN46012

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R0000	This visit was for a State Residential Licensure Survey. Survey dates: August 2, 3, and 4, 2011 Facility number: 012129 Provider number: 012129 AIM number: N/A Survey team: Donna M. Smith, RN, TC Toni Maley, BSW (August 2, 2011) Census bed type: Residential: 46 Total: 46 Census payor type: Other: 46 Total: 46 Residential sample: 9 These state residential findings are cited in accordance with 410 IAC 16.2. Quality review completed on August 4, 2011 by Bev Faulkner, RN	R0000	Submission of this plan of correction shall not constitute or be construed as an admission by CrownPointe of Anderson that the allegations contained in this survey report are accurate or reflect accurately the provision of service to the residents of CrownPointe of Anderson.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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R0144	(a) The facility shall be clean, orderly, and in a state of good repair, both inside and out, and shall provide reasonable comfort for all residents. Based on observations, record review, and interview, the facility failed to ensure a clean and sanitary environment regarding the condition of the resident's carpeting for 5 of 9 resident's apartments observed. (Room's - Resident #'s 4, 7, 30, 33, and 44) Findings include: 1. On 8/03/11 from 8:10 a.m. to 9:45 a.m., during medication reminders with CNA #1, the following was observed: As Resident #7 was being assisted by CNA #1, the resident's apartment carpeting was observed with black to gray soiled/stained areas of various sizes around the resident's bed, sink, and dresser areas. In Resident #4's apartment, gray to blackened soiled/stained areas were observed around the resident's bed, in front of her couch, and in the hallway at the kitchen entry way and the entrance to the apartment. In Resident #30's apartment, the resident indicated she liked her apartment but was	R0144	I. The involved resident's #4, #7, #30 and #44 carpet's have been cleaned and residents have been put on a carpet cleaning schedule.II. All residents could be potentially affected by the deficient practice. All resident apartments will be listed on a carpet cleaning schedule and carpets will be cleaned by maintenance staff quarterly. Maintenance staff will initial and date carpet cleaning schedule when each apartment's carpet cleaning is complete. Any carpets that need to be cleaned more frequently due to resident spills or incontinence will be cleaned on an as needed basis.III. As a means to ensure ongoing compliance, the housekeeper will check carpets weekly when cleaning the resident apartments and write a work order, if needed, to notify maintenance staff to clean carpet. If resident is prone to spills or incontinence issues staff will check carpets daily, write a work order and notify maintenance staff to clean carpet.IV. Administrator or designee will monitor carpet cleaning schedule monthly and work orders for carpet cleaning weekly to ensure all carpets are kept clean.	08/12/2011

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	unhappy with the grays spots at the entry way. The carpeting located at the entry of the apartment and from the kitchen entrance to the beginning of the resident's designated living room, a path of gray colored soiled/stained carpeting was observed. In Resident #33's apartment, the resident was observed to get up from her couch as CNA #1 entered the apartment. A large gray soiled/stained area was observed in front of the couch where the resident had been sitting. A lighter gray stained/soiled area was also observed around the resident's bed. 2. On 8/03/11 from 9:50 a.m. to 10:30 a.m., the environmental tour was conducted. At this same time during an interview, the Maintenance Supervisor indicated he would clean a resident's apartment carpeting if he received a complaint or saw stains or soiled spots on an apartment's carpeting. He indicated when a resident would move out, the apartment was cleaned, painted, toilet seat was replaced, and the carpeting was cleaned. He also indicated Resident #7's apartment carpeting had been cleaned frequently, but she would not always let the carpeting dry before she would go back into her room.			

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	On 8/03/11 at 10:35 a.m., the Maintenance Supervisor presented a list of 18 apartments indicated to have the carpet cleaned. At this same time during an interview, he indicated he did not have a set schedule for checking and/or cleaning apartment carpeting. 3. On 8/04/11 at 9:25 a.m., during an interview, Resident #44 indicated he had moved into his apartment in late 2/2011. He indicated his carpeting had black soiled areas scattered throughout his apartment. He indicated his carpeting had not been cleaned since he had moved in. On 8/04/11 at 9:45 a.m. with Resident #44's present, his apartment carpeting was observed. Gray to black soiled/stained areas were observed around his table and in the entrance area, which was also next to the kitchen area. Scattered black stained/soiled areas were also found throughout the apartment. At this same time during an interview, Resident #44 indicated his wheelchair and the oxygen tanks could be the cause of some to the soiled areas.			

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R0352	(e) The clinical record must contain the following: (1) Sufficient information to identify the resident. (2) A record of the resident ' s evaluations. (3) Services provided. (4) Progress notes. Based on record review and interview, the facility failed to ensure the progress notes of the clinical record contained current information related to a resident's change in condition for 2 of 3 records reviewed with a change in condition in a sample of 9. (Resident #27 and #44) Findings include: 1. On 8/03/11 at 2:10 p.m., review of the facility's infection control program from 10/10 to 7/11 indicated in the "INFECTION MONITORING LOG," Resident #27 had a urinary tract infection in 1/11 and 6/11. Resident #27's record was reviewed on 8/03/11 at 3:35 p.m. The resident's diagnoses included, but were not limited to, diabetic mellitus, bipolar, and anxiety/panic disorder. The "PROGRESS NOTES" indicated the following: No information was documented	R0352	I. The resident #44 was seen by a physician and received treatment. Subsequent assessment/evaluation of the clinical condition being treated are being documented in the applicable clinical record. For involved resident #27 we cannot retro-actively follow up with documentation. Health and Services Director will flag residents chart when family is called and follow up with family on the next scheduled work day.II. In an effort to identify any other residents who may be affected, current physical status concerns of all residents will be reviewed to ensure record of any applicable assessment and/or evaluation has been recorded in the resident's clinical record. Should concerns be noted, applicable nursing staff will be addressed and re-educated.III. As a means to ensure ongoing compliance, licensed nursing staff will be addressed regarding the need to ensure each clinical record contains sufficient information to identify the resident, record of the resident's evaluation, and services provided.IV. As a means of quality assurance, the Health and Services Director shall be	08/17/2011

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	concerning the urinary tract infection indicated in 1/2011. On 4/27/11 at 10:00 a.m., the resident had nasal congestion, cough, sneezing and was afebrile but hoarse. The family was notified. No further information was indicated concerning the respiratory symptoms identified. No information was indicated concerning the urinary tract infection indicated in 6/2011. On 8/03/11 at 3:45 p.m., during an interview, LPN #2 indicated she should have followed-up on the 4/27/11 respiratory symptoms. 2. On 8/04/11 at 9:25 a.m., during an interview, Resident #44 indicated he had a raised area on his right inner thigh and had told the nurse before she left on vacation at the end of July. He indicated she thought it could be an infected hair. He indicated he still had the area, which was now larger, black and bluish in color, and painful to touch. After he had checked with the nurse, he indicated he now did have a doctor's appointment for today concerning this area. Resident #44's record was reviewed on		responsible to monitor the shift to shift reports used to communicate resident concerns/conditions on scheduled days of work to ensure corresponding entries have been made in the resident's clinical record.	

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	8/04/11 at 9:25 a.m. The resident's diagnoses included, but were not limited to, skin cancer, positive for MRSA (Methicillin resistant staphylococcus aurous), positive for hepatitis, diabetic mellitus, and familia spastic paralysis. The "PROGRESS NOTES" indicated no information related to the area on the resident's upper right inner thigh from 7/2011 through 8/03/11. On 8/04/11 at 12:25 p.m., during an interview, LPN #2 indicated she would chart pertinent information and family notification in the resident's records. 3. The "RESIDENCY AGREEMENT" was provided by LPN #2 on 8/02/11 at 11:25 a.m. This current agreement indicated the following: "...8. HealthCare Services a. Observation. CrownPointe and/or the Facility, through its staff, shall regularly observe resident's health status to identify any changes in Resident's physical, mental, emotional and social functioning and will help Resident respond to Resident's dietary and health needs and the needs for special services....."			

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R0407	(b) The facility must establish an infection control program that includes the following: (1) A system that enables the facility to analyze patterns of known infectious symptoms. (2) Provides orientation and in-service education on infection prevention and control, including universal precautions. (3) Offering health information to residents, including, but not limited to, infection transmission and immunizations. (4) Reporting communicable disease to public health authorities. Based on record review and interview, the facility failed to ensure the current outlined infection control program was followed to monitor and track infections occurring in the facility to prevent the spread of diseases and infections. This had the potential to affect all residents in the facility. Findings include: 1. On 8/03/11 at 2:10 p.m., review of the facility's infection control program from 10/10 to 7/11 indicated the following: In the "INFECTION MONITORING LOG," Resident #27 had a urinary tract infection in 1/11 and 6/11. Resident #12 had bronchitis in 10/10 requiring the administration of an antibiotic. The months of 11/10, 12/10, 2/11, 3/11, 4/11, 5/11, and 7/11 indicated no infections	R0407	I. For involved residents #12 and #27 the facility can not retro-actively follow up with documentation in the chart to correspond with infection control log. Infection control program has been revised and forms were put into place to help communicate the possibility of infections. II. All residents could potentially be affected by the deficient practice. The infection control program has been updated to improve communication on possible infections.III. As a means to ensure ongoing compliance the infection control program has been updated. Health and Services Director will document in both infection control log and resident chart on same day when an infection is identified. Chart will be flagged by Health and Services Director for follow-up to ensure infection is resolved.IV. Administrator/Designee will monitor infection control log	08/15/2011

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	were reported. The form, "RESIDENT REPORT OF INFECTION," dated 4/98, indicated information regarding the symptoms, type of infection, culture results, and/or antibiotic ordered with follow-up questions to be completed by the nurse. No information was indicated related to this form. In this program the "INFECTION SURVEILLANCE" indicated the following: "POLICY: ...Surveillance of residents will include: * maintenance of an infectious disease log by facility staff. * reporting individual incidents of infection. * monthly recording of incidents by infection sites. * recording utilization of antibiotics, antiseptics and other anti-infection drugs....." 2. On 8/03/11 at 3:30 p.m., during an interview, LPN #2 indicated with being the only nurse it was difficult to find out if a family had taken a resident out for a problem, especially on weekends.		weekly and check resident chart if resident is listed in the log. Administrator/Designee will sign off and date infection control log weekly for 3 months then 1 time a month ongoing. Administrator/Designee and Health and Services Director will review infection control log quarterly.	

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	On 8/04/11 at 8:55 a.m., during an interview, CNA #1 indicated she would notify the nurse verbally if she observed a problem with a resident, for example, not "acting normal" or a rash. She indicated she was not aware of any form to be completed if a resident showed signs different from their normal status. On 8/04/11 at 9:00 a.m., during an interview, LPN #2 indicated staff would report to her any problems/concerns with residents as the CNA's were not utilizing the "RESIDENT REPORT OF INFECTION" to indicate any new symptoms displayed by the resident. 3. Resident #27's record was reviewed on 8/03/11 at 3:35 p.m. The resident's diagnoses included, but were not limited to, diabetic mellitus, bipolar, and anxiety/panic disorder. The "PROGRESS NOTES" indicated on 4/27/11 at 10:00 a.m., the resident had nasal congestion, cough, sneezing and was afebrile but hoarse. The family was notified. No further information was indicated concerning the symptoms identified with the next notation on 5/23/11 at 10:00 a.m., concerning a fall. On 8/03/11 at 3:45 p.m., during an			

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	interview, LPN #2 indicated she should have followed up on the 4/27/11 respiratory symptoms.			
R0414	(k) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. Based on observations, record review, and interview, the facility failed to ensure handwashing and glove use were performed in a manner to prevent the spread of diseases and infections for 2 of 3 staff personnel observed. (CNA #1 and Activity Director) (Resident #'s 4, 33, 23, and 44) Findings include: 1. On 8/03/11 from 8:10 a.m. to 9:45 a.m., during medication reminders with CNA #1, the following was observed: After CNA #1 assisted Resident #4 with her locked box and medication container, she was observed to handwash, turn the water off with her wet hands, and then dried her hands. Next, CNA #1 was observed to change two of the resident's monitor patches she presently was wearing and threw them away. She then handwashed using the resident's dishwasher soap.	R0414	I. For involved residents #4 and #33, apartments will be furnished with hand soap. For involved residents #23 and #4, C.N.A #1 was counseled and re-educated on hand washing hygiene, use of gloves and the use of alcohol rubs.II. All residents could be potentially affected by the deficient practice. All resident apartments will be furnished with hand soap. All staff will be re-educated on hand washing, use of gloves, and use of alcohol rubs.III. Hand washing soap will be stocked in the supply room for housekeeping and C.N.A staff to distribute to apartments as needed. Hand washing and infection control inservices are scheduled for 6:30 am and 2:00 pm on 8/17/11 to re-educate all staff on hand washing hygiene, use of gloves and use of alcohol rubs.IV. Administrator/Designee will monitor hand soap supply and reorder as needed. Health and Services Director will observe the C.N.A doing med reminders starting week of 8/15. 1st week 3	08/17/2011

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	After CNA #1 assisted Resident #33 to her kitchen counter from the couch, she assisted the resident to open her medication container. After the resident had taken her medications, CNA #1 was observed to use the resident's dishwashing soap to wash her hands. As CNA #1 assisted Resident #23 with her medications, she dropped one pill in her lap. CNA #1 picked it up from the resident's lap and put it into her hand as she dropped it again. CNA #1 again picked up the pill with her hand and put the pill in the resident's hand. Resident #23 then took all of her medications. 2. On 8/03/11 at 1:55 p.m., in the ice cream parlor, the Activity Director with gloved hands was observed to throw a three gallon sized used ice cream container in the wastebasket. Next, she was observed to rinse her gloved hands off and dry them. Then, with the same gloved hands she was observed to finish preparation and serve ice cream. Resident #44 and #23 were present in the ice cream parlor for their ice cream as other residents were arriving. 3. On 8/03/11 at 2:05 p.m., during an interview, LPN #2 indicated CNA #1 could have used a glove to pick up the		times each on 1st shift, 2nd week 2 times on 1st shift & 2nd shifts, 3rd week 1 time on 1st & 2nd shifts. Health and Services Director will do random checks 2 times a month on 1st & 2nd shifts on going. Monitored times will be documented in log book.I. For involved residents #44 and #23 the activity director was verbally counseled and re-educated on the use of gloves by the Health and Services Director.II. All residents could be potentially affected by the deficient practice. Activity Director has been re-educated on hand washing hygiene and the use of gloves by the Health and Services Director.III. Activity Director is required to attend the handwashing and infection control Inservice on 8/17/11.IV. Administrator/Designee will observe Activity Director starting week of 8/15-3 times the first week, 2 times the 2nd week and one time the 3rd week and will do on going random checks. Administrator/Designee will initial off on activity calendar the days ice cream parlor is monitored.	

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	dropped pill. She also indicated soap was not supplied to the residents in their apartment, and handgel could be used. 4. On 8/04/11 at 8:50 a.m. during an interview, the Activity Director indicated she should have removed her gloves after throwing the ice cream container away and handwashed. 5. The "HANDWASHING/HAND HYGIENE" policy was provided by LPN #2 on 8/03/11 at 2:00 p.m. This current policy indicated the following: "POLICY: The employee should wash his/her hands routinely after each direct resident contact (as indicated by accepted professional practice) and after handling contaminated articles.... Handwashing is the single most important measure for preventing the spread of infection. ...HANDWASHING PROCEDURE: ...6.) Rinse thoroughly... 7.) Pat dry your wrists and hands with paper towels. 8.) Turn off faucet with paper towel and discard paper towel. Remember, the			

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	handle is considered contaminated....."			